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Editorial

Audit: time to rethink

Doctors carry out 20,000 audit projects each year. This will have cost the NHS £834 million by the end of the century.[1]

What is the benefit to patients? Most clinicians would immediately reply "very little". The NHS Executive is more guarded in reply, but, tellingly, has commissioned more research on the value of audit.

The NHS Audit Initiative was formally launched in the Health Service reforms of 1990, and audit became a contractual requirement for hospital doctors (though not for general practitioners). Some doctors therefore felt compelled to participate in audit with their peers; many, however, have declined to become involved. I have not heard of any disciplinary action being taken against any doctor who has failed to take part in audit.

Medical audit committees were set up and audit assistants employed. More recently, the NHS has directed all audit funding at clinical (multiprofessional) audit as distinct from medical (uniprofessional) audit. Evidence-based medicine, risk management and protocol drafting have become mixed up with audit activity. The NHS has funded several centres of audit and evidence-based medicine, often with overlapping functions.[2] Little of this has penetrated to the clinician or altered daily practice.

Hospital doctors have become increasingly cynical about the value of audit.[3] They see scarce resources being diverted by political dogma without evidence of benefit. The initiative has been taken out of doctors' hands by non-clinicians, who have created an audit industry with its own jargon, literature and career structure. No wonder doctors merely pay lip service to audit while quietly ignoring it.

What can be done to redress the drift from the sensible aim of audit – to improve the quality of our care for patients? There are several measures which, from my experience as a hospital audit co-ordinator, I feel would help.

- No audit project should be started unless all members of the group agree at the outset that they are prepared to change practice if this is indicated by the conclusion. This is a key requirement, whose absence explains why so many audit projects fail to achieve change.
- Audits should preferably be national projects, with agreed national standards. (The National Cataract Audit is a good example.) Small, local, ad hoc projects should be discouraged as they seldom measure against accepted national standards and the conclusions are rarely acted on or re-audited.
- Doctors should retain control of medical audit projects, and resist managerial audit, which is differently motivated.
- Doctors should clearly distinguish research from audit. Research provides the evidence for a standard of practice; audit measures how an individual is performing against that standard.
- Audit assistants should be used from the early planning stages.

Let us stand up and admit that current audit practice is failing. We should demand a rethink, before audit is totally discredited.

At present, most doctors would be happy to see audit sacrificed as our annual efficiency savings; I do not think patients would suffer. Indeed, some of them might well ask why we have wasted so much of their money on such unaudited activity.

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REFERENCES

1. Clinical Audit in England. National Audit Office, London. HMSO 1995.
2. Promoting Clinical Effectiveness (Annex 3a) 1996. NHS Executive 3903 2AR.
3. Hopkins A. Clinical Audit: time for a reappraisal? *J Roy Coll Physicians London* 1996; **30**: 415-25.